

*Claims Payment**

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Learning Objectives

An understanding of the material in this chapter should enable you to

- 5-1. Identify what constitutes a loss under each form of health insurance.
- 5-2. Describe settlement practices that are deemed unfair.
- 5-3. Explain how agents may help clients meet their claims payment expectations.
- 5-4. Summarize the steps in the claims payment process that are common to health insurance policies.
- 5-5. Explain how medical expense claims are paid on a service basis and an indemnity basis.
- 5-6. Describe the claims payment features specific to disability income policies.
- 5-7. Identify the claims payment features specific to long-term care policies.

Chapter Outline

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claims payment

Like underwriting, claims payment is essential to all forms of insurance. *Claims payment* is the process whereby an insurer determines its obligations under a policy for a claimant's covered losses and provides benefits for such occurrences in accordance with the policy's terms. In medical expense insurance, the covered loss is typically medical expenses incurred or services received due to injury, illness, or maintenance of health. In disability income insurance, income forgone because of an illness- or injury-related inability to earn a living constitutes the covered loss. In long-term care insurance, the covered loss relates to a cognitive or physical impairment that results in an inability to care for oneself and dependency on others.

From the claimant's viewpoint, claims payment is the purpose for which the insurance was purchased. At the very least, the claimant rightfully expects this process to be easily accessible, accurate, fair, complete, and prompt. The service and performance that an insurer demonstrates in the claims payment process are the true measures of the insurance contract's value to the policyowner.

At the same time, an insurer's claims payment practices represent a major source of possible mistreatment of claimants. Most states now have enacted laws patterned after the NAIC's model laws and regulations pertaining to unfair claim settlement practices. Some of the practices that are regarded as unfair are the following:

- failing to investigate claims promptly
- failing to communicate with or acknowledge communications from claimants on a timely basis
- failing to provide a reasonable explanation as to why a claim was denied
- failing to maintain procedures for handling complaints about claims
- misrepresenting pertinent policy provisions that affect claims
- failing to try to settle a claim once the insurer's liability becomes clear
- attempting to settle a claim for far less than a reasonable person would expect based on the insurer's advertising material

The agent, who is essential to the underwriting process, also has a key role in the success of the claims payment process. Health insurance claims usually occur when insured persons are unprepared: they are dealing with an illness, accident, disability, or loss of independence. They are also unlikely to be fully aware of the details of their policy's provisions, especially those relating to claims payment. By serving as an advisor to insureds at this time with respect to both coverage and claims provisions, the agent provides an

important client service function. The agent can explain a policy's claims process as well as assist with claims filing and reporting on claims payment status. Insurers encourage this important agent role by providing the agent with claims payment resource information, including forms to assist an insured who is filing a claim. Understanding claims payment, consequently, equips the agent to be a better client advocate.

Example:

Anita is a career agent with significant experience in long-term care insurance. When her clients receive their policies, she counsels them to call her if they believe they need to file a claim. She reinforces this recommendation by relating the story of a wife who called her long after her husband had been receiving covered home care services only to find out that some of her claims were being denied; the caregivers in many cases were uncertified as the policy required.

When clients call as she requests, Anita carefully reviews all the claims payment requirements of their policies. In this way, she assists her clients to avoid claims pitfalls and to maximize the payment of appropriate benefits. Among the topics she covers are: timely filing of claims; the types of care services covered; the extent and limitations of benefits for covered services; documentation required; and the advantages of the using a care coordinator as allowed or required under the policy. She emphasizes that claims filed under a plan of care developed by a care coordinator who has certified the need for care are more likely to be accepted by the insurer and processed problem free.

In general, as the following discussion indicates, the payment of health insurance claims under medical expense, disability income, and long-term care policies share many common features. These common features result from the NAIC's Uniform Individual Accident and Sickness Policy Provision Law (UPPL), which all states have adopted in some form. Chapter 6 discusses the UPPL in more detail. The discussion in this chapter also notes claims payment features that are specific to each of these forms of health insurance.

COMMON FEATURES

Each policy spells out the steps that the claimant must follow, as well as his or her responsibilities following a loss. In certain cases, the claimant will be both the policyowner and the insured. In other cases, such as under a medical expense policy that covers family members, the claimant will be the policyowner who files claims for a child or other insured family members. The claimant's failure to follow any necessary procedures may jeopardize the receipt of benefit payments and the ability to bring legal actions against the insurance company if disputes arise. However, at times, especially with disability income and long-term care coverage, the claimant may be incapacitated and the necessary duties of complying with claims provisions will fall to the claimant's legal representative.

The steps in the claims payment process, including those applicable to health insurance policies, fall into four general categories: (1) the claimant furnishes a notice of loss to the insurer, (2) the policyowner files a proof of loss with the insurer, (3) the insurer examines the claim, and (4) the insurer makes or denies the claim payment, sometimes after negotiating the amount to be paid. These steps are logically distinct and may extend over the course of weeks or even months in the case of disability income and long-term care insurance claims. Alternatively, two or more of these steps may occur at the same time. For example, in the case of medical expense insurance, these steps often occur in rapid succession and nearly simultaneously thanks to electronic data transmission technology.

Notification

The claimant must first notify the insurer that a claim is being made. Notification to the insurer must be provided as spelled out in the policy. Often, the time frame is specified as "immediately," "promptly," or "as soon as reasonably possible" after a loss occurs or a covered service is received. Some policies may require notice within a specific time frame, such as within 30 or 180 days after the occurrence of a loss. In most cases, the policies contain the insurer's contact information. Many insurers prefer written notification of a claim rather than notice by phone or through the Internet. Some insurers initially do little other than send the claim forms to the claimant with instructions to have them completed and returned to the insurer. The insurer must supply claim forms within 15 days after the insured gives notice of claim. However, many insurers are proactive and work with the claimant to ensure that all necessary paperwork is properly completed. In practice, an insurer rarely penalizes a claimant for failure to give timely notice, if the insurer suffers no detriment as a result.

Proof of Loss

In the second step of the process, the insurer requires that it receive a proof of loss. For most medical expense policies, as explained later, a health care provider often accomplishes this step directly with the insurer. Disability income and long-term care policies as well as some medical policies state that no claim will be paid unless a proof-of-loss form is filed within a specified time, which may range from 90 days to one year after the start of covered services or the commencement of a disability claim, unless the claimant is legally unable to comply. As in the case of notification, companies sometimes do not adhere strictly to the required time period and may accept claims filed beyond the period specified in the policy.

The proof of loss under health insurance policies usually is submitted using claim forms supplied by the insurer to determine its payment responsibility. These forms consist of a claimant's statement as to the dates and nature of the loss incurred and/or treatment received. Statements on the form or attached to the form from a physician or other licensed health care provider must document that the claimant meets the conditions to qualify for benefits. For disability income and long-term care claims, providers must specify how long the claimant's condition is expected to continue. The claim form also contains an authorization from the claimant or other covered person which permits any medical provider to release records or information concerning the claimant's medical history and current condition. Information gained from such a release is often essential to the claim because it demonstrates proof of loss. In the case of disability income insurance, this authorization extends to employer release of information indicating the dates and reasons that a claimant's active employment ceased. The insurer also reserves the right, at its own expense, to have the claimant examined by a physician of its own choice as may be reasonably necessary to verify a claim.

Periodically, during an extended claim-paying period, the insurer may also require verification that the claimant continues to satisfy the criteria to receive benefits. Continued verification is more likely under disability income and long-term care policies due to their extended periods of benefits than under a medical expense policy.

Examination

Claims examination, the third step, determines whether a loss occurred and, if so, whether the policy covers it. Some of the questions that may have to be resolved include the following:

- What is the effective date of coverage?
- When did the loss occur and was the coverage in effect on that date?

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- Is the loss covered, and if so, what benefits, exceptions, and exclusions, if any, apply?
 - What conditions affecting the claim must occur or be satisfied?
 - Is there evidence of misrepresentation?

contestable period

With specific reference to this last point, misrepresentation calls into question the validity or legitimacy of claims with respect to the truth of their content and possibly to the truth of statements made previously on the application for insurance. As chapter 3 explains with examples, if there is material misrepresentation on an application, insurers have the right to deny claims and rescind (with a return of premium) or deny the claim and offer to reform a contract. Insurers generally maintain this right for a period of time, known as the *contestable period*. The contestable period is usually 2 years after a policy is issued, but some states allow 3 years. Thus, any claims filed within the contestable period are subject to a special level of investigation to determine if the information provided on those claims also provides evidence of misrepresentation on the application. Most misrepresentations pertain to health conditions prior to the date of the application, but may also extend to misrepresentation of income in applications for disability income coverage.

Payment

Finally, the amount to be paid must be determined in one of three ways: (1) payment of the claim in full, (2) payment of a different amount than the claimant might initially expect, or (3) denial of the claim. Numerous policy provisions may be applicable. These include provisions that

- deal with other insurance covering the same loss;
- provide for a deductible, coinsurance amount, or waiting period;
- and/or impose a specific limit on the insurer's responsibility for certain types of claims or the total of all claims.

Payment may be a single action or decision, as it is when a medical expense claim is paid for a one-time treatment of a minor illness in a physician's office. For all forms of health insurance, however, payment is more frequently complex; multiple payment decisions must be made because claims for each loss or event usually have several related components. Moreover, these more complex claims often involve component claims that occur over a period of time. A medical expense claim may involve a hospital stay as well as follow-up physician office visits, or therapy extending over weeks or months. In the event of a disability or the need for long-term care, the period is likely to be many months or years. In addition, multiple losses and events may occur over the period that a health insurance policy remains

in force. Consequently, the payment of claims also requires management of claims; a specific claim or component of a claim must be paid within the context of a policy's applicable benefit provisions for covered losses or events as well as its maximum lifetime benefits.

Health insurance benefits can generally be assigned to providers of care as is common in the case of medical expense and long-term care insurance. Benefits may be assigned to another party if such an assignment is permissible under state law and the insurance contract.

**facility-of-payment
provision**

If an insured person is physically, mentally, or otherwise incapable of giving a valid release for any payment received, a *facility-of-payment provision* allows payments to be made to a legal representative, frequently referred to as a guardian.

Example: Marcia is senior software engineer at a small information management company whose employment benefit program does not contain long-term disability coverage. Marcia, wishing to better protect her six-figure-income lifestyle, obtains an individual disability income policy with a 90-day waiting period. Within a year after the policy issued, she is diagnosed with multiple sclerosis, a permanent and degenerative disease of the central nervous system. Although periods of remission allow Marcia to remain on the job for several months after her diagnosis, the rapid progression of the disease, which severely affects her sensory and motor functions, soon prevents her from performing the duties of her job.

Marcia notifies her insurer of her disability in a timely manner and receives claims forms which she completes and submits along with attending physician's statements describing her disability. Because Marcia's claim falls within the 2-year contestable period, her insurer thoroughly investigates her claim and the information previously provided on her insurance application together with all relevant medical record data over the last several years. The insurer also accesses MIB's Disability Income Record Service and Health Claims Index to make sure no unusual policy application or claim activity has occurred since the policy was issued.

The insurer confirms Marcia’s disability status and finds no evidence of any misrepresentation or concealment with respect to the diagnosis or treatment of her current condition prior to her application for insurance. Her claim is approved. Because she is totally disabled, the insurer begins to pay Marcia the full monthly disability benefit upon the expiration of the 90-day waiting period.

SPECIFIC FEATURES

Claims payment features are also specific to the form of health insurance. The following section highlights some of the unique features of medical expense, disability income, and long-term care insurance. Subsequent chapters that cover regulations and benefits of each health insurance product provide further explanations of these and other claims payment provisions.

Medical Expense Insurance

indemnity basis

The previous discussion on the presentation of proof of loss requiring the filing of claims forms is largely relevant to medical expense policies (as well as other types of policies) that provide benefits on an *indemnity basis*. Such policies often reimburse a claimant for the incurred expense of medical services received and therefore require documentation concerning the occurrence, nature, and extent of each claim.

service basis

In today’s market, however, managed care plans—in particular PPOs as well as HMOs and the plans of other organizations like Blue Cross and Blue Shield plans—dominate the comprehensive medical expense insurance market. These plans provide benefits on a *service basis* because they have contractual agreements with health care providers and networks of health care providers for the delivery of medical care to covered persons and generally do not require these insureds to file claim forms. Rather, the providers of services perform any necessary paperwork and are then reimbursed directly without any need for an assignment of benefits from the claimant. Some network providers have arrangements that pay them on a per-member-per-month basis to render any service to an insured (referred to as a plan member or enrollee) who uses that provider for care. This practice is called *capitation*. The providers file patient encounter forms with the insurers that are like claim forms but produce no payment for a specific service.

capitation

When physicians and other licensed health professionals or institutions present a claim to the insurer whose plan provides benefits on a service basis, the insurer must determine one or more of the following:

- the care provider's status as a network participant
- the primary or specialty care nature of the service if rendered by a network participant
- the applicability of medical management requirements, including authorizations for service, utilization or care quality parameters, and care management
- the pricing of the claim, including determination of the payment amount, the amount paid to the provider, and the claimant's cost sharing

Depending upon the plan's stringency, the provider's reimbursement may be denied altogether or be far less than the amount charged if the claimant receives services from a nonnetwork provider or if a specialist is seen without a required referral. In turn, the payment made to the provider determines whether the enrollee must pay a modest copayment, a more substantial amount under an indemnity benefit as described above, or the total amount if a claim is denied.

Example:

Alex has a medical expense policy that requires him to receive care from physicians who participate in a preferred provider network. After an office visit to Dr. Lexa, who participates in the network, Alex pays a \$10 copayment and the doctor files a claim for Alex's office visit directly with the insurer in whose network she participates. The doctor subsequently receives payment of \$70 which together with Alex's copayment represents the negotiated rate for Alex's service.

Alex's brother, Axel, also visits Dr. Lexa and receives the same level of service. However, Dr. Lexa does not participate in the network utilized by Axel's insurer. In addition, Dr. Lexa does not accept assignment of insurance benefits and requires Axel to pay her standard \$90 fee for an office visit at the time of service. As a courtesy, Dr. Lexa does file the claim with Axel's insurer who subsequently

makes the claim payment directly to Axel, subject to applicable deductible and personal participation amounts required under the policy.

Disability Income Insurance

Claims payment features specific to disability income insurance are summarized under the headings of the complexity of the claims examiner's responsibility, the definition of disability, and rehabilitation.

Claim Examiner Responsibility for Claims

Similar to the importance of the underwriter's determining what investigation is necessary when first evaluating the insurance application, the disability claim examiner must determine the legitimacy and severity of the disability early in the claim process. Although contract language and definitions help to resolve many potential problems, each individual claimant has a set of complex circumstances and motivations. As a result, determination of a legitimate disability is not always clear and frequently has many subjective qualities. An insured's decision to file or extend a disability claim can be effected by such subjective factors as a:

- business downturn
- desire to "retire" early
- lack of financial incentive to promptly return to work

Proper investigation and analysis of available information are critical to the proper handling of the claim. Naturally, the depth and detail of the investigation depend on the claim's circumstances—particularly the projected length of disability, the severity of the disability, and the subjectivity of the impairment. All of these variables must necessarily be weighed against other variables, such as the claimant's occupation and age. In addition to obtaining the types of routine claim form information discussed previously, the claim examiner may utilize other information sources that include the following:

- Disability claim examiners frequently develop important and reliable information on a disability by dealing directly with the claimant over the telephone.
- Inspection reports (similar to those discussed in the previous chapter on underwriting) may be used when there is a question of the degree of disability, verification of occupation information, income

questions, or possible overinsurance. These reports may take the form of an investigation and even surveillance, if there is suspicion of misrepresentation or fraud.

- A CPA or other financial consultant available to claim examiners may review certain claims involving large amounts, residual benefits, business insurance, or complex financial situations.
- Independent medical examinations (IMEs) are reserved for those instances where a disability is of potentially long-term duration and where the degree of recovery is in question. Calling in an IME at the insurer's expense is an important method of obtaining third-party input concerning the disability's severity.
- In recent years, many companies have used functional clinical evaluations (FCEs) to determine more accurately the extent or degree of disability. The criteria used in these evaluations are much like the standards for the ability to perform activities of daily living used in long-term care insurance.
- MIB's Disability Income Records System (DIRS) alert insurers to problems of overinsurance, particularly during the contestable period.
- Although only a small percentage of claims result in a personal visit and contact from a claim department representative, face-to-face verification of the circumstances surrounding the claim is necessary in some situations.

Disability Definition

The general concept of the payment of claims under a disability income policy is clear—replacement of a portion of an insured person's income when that person becomes totally disabled. However, the term disability may be defined and understood in many ways. Insurers strive to define disability as precisely as possible. Nevertheless, its application to a specific person's situation for the payment of only legitimate claims requires skill and good judgment. Claims payment denials based on the definition of disability are a frequent cause of litigation involving disability income policies.

The two major definition categories are total disability, in which the full disability benefit is paid, and less than total disability, in which only a portion of the full benefit is paid. The various definitions of disability are discussed in chapter 12.

Rehabilitation

By paying claims, all forms of health insurance to a greater or lesser degree have rehabilitation as one of their purposes. Medical expense

insurance pays benefits to restore and maintain a person's health. Although less frequently the case in long-term care insurance, the claims paid may allow a person to become independent once again. However, rehabilitation is most visibly associated with the claims payment function under disability income insurance. Rehabilitation provisions in a policy or in benefit administrative practices can effectively encourage a claimant to return to work as soon as reasonably possible, thereby eliminating or reducing claims payments. Some companies have introduced strong rehabilitative policy language in response to claims problems. These may include contractual provisions that

- require that a claimant be receiving appropriate medical care for his or her impairment.
- include mandatory rehabilitation to maintain benefits, if the claimant is a candidate for return to work or rehabilitation.

**disability
management
program**

Rehabilitation, as implemented by disability income insurers, encompasses a comprehensive set of procedures and functions usually known as a *disability management program*. A disability management program includes:

- early intervention in a disability case by coordinating the handling of specific claims and the entire claims record for the disability
- coordinated use of various professionals (physicians, nurse case managers, psychiatric nurses, rehabilitation specialists, and accountants) to determine the right approach for a specific case
- assisting claimants with the process of filing for disability benefits under Social Security when the circumstances warrant it

Example:

In a continuation of the earlier disability income insurance example, Marcia's insurer implements a disability management program that, along with her medical treatment, encourages her to perform a portion of her duties by working from home during periods of remission. Marcia is pleased with this arrangement for a number of reasons including the fact that her reduced salary is supplemented by a partial disability benefit payment allowed in this situation under her policy. As result, she suffers little in the way of lost net income. Although this arrangement works well over the next couple of years, it is only temporary; Marcia's periods of

remission become fewer and shorter. As a result, she returns to total disability status and again receives the full monthly disability benefit.

Long-Term Care

When insureds file a claim under a long-term care policy, the policy provisions spell out the procedures that must be followed. These procedures generally follow the claims payment features common to health insurance policies as discussed previously. Nevertheless, there are claims payment features specific to long-term care policies. In many cases, the insured will be incapacitated and the necessary duties of complying with claim provisions will fall to the insured's legal representative. In such situations, the assignment of benefits to providers of care reduces a family's involvement in handling financial matters directly. However, benefits cannot be paid, assigned, or pledged as collateral for a loan.

Other claims payment features specific to long-term care policies can be summarized under the headings of the payment basis, use of a care coordinator, and the effect of federal legislation. Chapter 19, which explains the benefit provisions of long-term care insurance policies, describes these features in greater detail.

Payment Basis

A long-term care insurance policy may pay benefits on a per diem basis or a reimbursement basis.

per diem basis

Under policy that uses a *per diem basis*, benefits are paid at the policy's daily, weekly, or monthly benefit level regardless of the actual cost of care. In this case, a policy with a daily benefit of \$200 will pay \$200 even if actual charges for care for the day are only \$150. Indeed, some of these policies, known as disability-based policies, pay benefits even if no expenses are incurred as long as the claimant meets the criteria for a covered cognitive or physical impairment.

reimbursement basis

The majority of newer policies, however, pay benefits on a *reimbursement basis*. These policies reimburse the claimant for actual expenses up to the specified policy limit. Thus a policy with daily benefit amount of \$200 will pay only \$150 if that was the claimant's actual charge for a day's care covered by the policy.

Care Coordinator

When the claimant notifies the insurer that a claim is being made, the insurer may provide the services of a care coordinator, also known as a care

manager, at no additional charge to the policyowner. Care coordinators occupy a pivotal position in the determination of benefits in some long-term care insurance policies, although their use varies by both company and policy. Some policies require the use of a care coordinator. In others it is optional, and in still others it is not available, particularly in older policies.

care coordinator

A *care coordinator* is a health professional whose responsibilities include screening claimants, determining eligibility for services, conducting provider referrals, monitoring outcomes, and counseling families. The coordinator also develops a plan of care based on a comprehensive assessment of the claimant's physical and cognitive needs, social situation, health condition, and other factors. The physician, the claimant, and the claimant's family participate in its development. The plan not only addresses care needs, it also identifies associated issues that may affect family stability and require the use of community services as well. Much of the planning revolves around the use of home care versus community care services and which services best match the needs of all parties involved. In some policies, the use of a care coordinator may waive the elimination period for certain services. Typically, insurers contract with care coordination firms to provide the service to their policyowners.

Federal Legislation

Federal legislation, known as HIPAA (discussed in the following chapter), grants tax-preferred status to long-term care policies that contain specific provisions (discussed in chapter 18). As a result, more than nine out of ten policies now sold comply with these provisions, which affect claims payment in a number of ways. Benefits may be paid only if the insured is certified as meeting the definition of chronically ill required by the law. In addition, the chronic illness must be expected to last at least 90 days, with recertification no less than every 12 months. The initial and any subsequent certifications must be made by a physician or other licensed health care practitioner.

CHAPTER REVIEW

Key Terms

claims payment	capitation
contestable period	disability management program
facility-of-payment provision	per diem basis
indemnity basis	reimbursement basis
service basis	care coordinator

Review Questions

Review questions are based on the learning objectives in this chapter. Thus, a [5-3] at the end of a question means that the question is based on learning objective 5-3. If there are multiple objectives, they are all listed.

1. What constitutes a covered loss under each form of health insurance? [5-1]
2.
 - a. What claims practices are identified as unfair? [5-2]
 - b. What do claimants expect from the claims payment process and how can health insurance agents help them meet their expectations? [5-3]
3. What time frames may be associated with a notification of loss? [5-4]
4.
 - a. How is proof of loss typically submitted under a health insurance policy? [5-4]
 - b. What kinds of statements and authorizations are required? [5-4]
 - c. Why may continued verification be required? [5-4]
5. What questions are typically resolved in determining whether a loss occurred and whether the policy covers it? [5-4]
6.
 - a. What policy provisions are applicable when determining the amount of a claim payment? [5-4]
 - b. Why does claims payment often require multiple claim decision for the same event? [5-4]
7. Under what circumstances can benefits be assigned? [5-4]
8. How does the process for paying medical expense claims differ depending on whether benefits are paid on a service basis or an indemnity basis? [5-5]
9.
 - a. What factors make the disability claims examiner's responsibilities complex? [5-6]
 - b. What information sources may the disability claims examiner utilize? [5-6]
10. Why is it important for a policy to precisely define the term disability? [5-6]
11.
 - a. What contractual provisions pertaining to rehabilitation have some companies introduced in response to disability claims problems? [5-6]
 - b. What disability management procedures and functions might a company implement? [5-6]
12. Describe the elements that a care plan developed by a care coordinator may include. [5-7]